MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10696

10693

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: James | Middle: Joseph | Last: Ahern, Sr. | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] | Month: AUGUST | Day: 4, | Year: 1969 | 2b. HOUR: 11a M | | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: June 24, 1928 | 6. AGE (In years last birthday): 41 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | | 2c. DATE PRONOUNCED DEAD: Month August Day 4, Year 1969 | | | 2d. HOUR: 11a M |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH: Rawlings | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL-DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: Construction | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Rawlings | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER | | | | | | | |
| 14. FATHER'S NAME: First Joseph | Middle Ahern | Last | 15. MOTHER'S MAIDEN NAME: First Eva | Middle | Last Butts | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes | If so, give war or dates of service: WW 2 | 16b. SOCIAL SECURITY NO.: 723-09-0127 | 17. INFORMANT: Gertrude Ahern-Rawlings, Md. | ADDRESS | | | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): GUNSHOT OF HEAD

DUE TO, OR AS A CONSEQUENCE OF (b): (SELF INFLICTED)

DUE TO, OR AS A CONSEQUENCE OF (c):

955X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDENX

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X] Inspection [X] Inquiry [X] and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: AUGUST 4, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/7/69 | Philos | Westernport Alle. Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| E. J. Boal | Westernport, Md. | AUG 7 1969 | Charles Judge |

VR A15ME (5)
10M REV. 1/68

1

10697

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10694

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| RUSSELL | LESTER | ASH | AUGUST 20, 1969 | 9:25AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | DECEMBER 12, 1897 | 71 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | Retired Employee- | CELANESE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | | RT. #1, VALLEY ROAD |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| AMON | | ASH | (ADAMS) MATTIE | | ASH |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 214-07-4892 | HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WEEKS

4109

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5 - 9, 1958, to 8 - 20, 1969, that (I) (we) last saw the deceased alive on 8 - 20 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| R.L. Breen M.D. | | [X] | [ ] | [ ] | 8-21-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| R.W.BALLIN, M.D. | 62 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/22/69 | P.O.S. of A Cemetery | Centerville Bedford Penna |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SILCOX FUNREAL HOME- 404 DECATUR ST. CUMBERLAND, MD. 21502 Merritt- | AUG 25 1969 | |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the deoth certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10698

# CERTIFICATE OF DEATH

10695

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| CLEAL | L. | ASHENFELTER | 8 | 3 | 69 | 1:47 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 1/18/02 | 67 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| WEST VA. | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life. Even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | Retired Mach. Helper | Railroad |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. VA. | MINERAL | WILEY FORD | YES [ ] NO [X] | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| CHARLES | E. | ASHENFELTER | ISABELLE | | BLACKBURN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 214 05 9402 | SACRED HEART HOSPITAL -900 SETON DRIVE CUMBERLAND, MD. 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | acute myocardial infarction | 36 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | arteriosclerotic Heart disease | 4 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Diabetes mellitus | 4 yrs. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Lung Disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot (I) (this hospitol) ottended the deceosed from 8-1, 1969, to 8-3, 1969, that (I) (we) last saw the deceased alive an 8-2 1969, and that in (my) (aur) opinian death accurred an the date and haur and fram the causes stated above, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 8/3/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. J. A. PAGAN | 1068 NATIONAL HIGHWAY -LAVALE, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 6, 1969 | Sunset Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SCARPELLI FUNERAL HOME -108 VA AVE -CUMB., MD. | AUG 6 1969 | [signature] |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 haurs after death.

VR A15 (1)
45M - 1X69

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (11) 45M - 69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10699

10696

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| VIOLA | | ATKINSON | AUGUST 3 1969 | 3:50 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| FEMALE | WHITE | 11-8-98 | 70 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATES | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | MEMORIAL HOSPITAL | | Housewife |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | Allegany | MIDLOTHIAN | YES ☐ NO ☐ | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | W. | MERRILL | ELIZABETH | | WALKER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | 216-10-4564 | MEMORIAL HOSPITAL CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) HEART FAILURE, R+L, due to Hy- — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14 days

DUE TO, OR AS A CONSEQUENCE OF (b) pervasive + arteriosclerotic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4121

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 7/22, 1969, to 8/3, 1969, that (I) (we) last saw the deceased alive on 8/2 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE H. Heinesman DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 8/3/69

22d. PHYSICIAN'S NAME (Type) H. Heinesman MD for DR. BLAIN SCHINDLER — 22e. ADDRESS 54 Greene St Cumberland Md

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | AUGUST 6, 1969 | FBG. MEMORIAL PARK | FROSTBURG ALLEGANY MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| DURST FUNERAL HOME | FROSTBURG, MARYLAND | AUG 11 1969 | Charles Judge |

10700

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10697

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: GEORGE | Middle: W. | Last: BANZHOF | 2a. DATE OF DEATH: Month AUGUST Day 20 Year 1969 |
| 2b. HOUR: 4:35 A M | | | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 3-30-95 | 6. AGE (In years last birthday): 74 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Mens Locker Room- | 12b. KIND OF BUSINESS OR INDUSTRY: Cumb'd Country Club |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] |
| 13e. STREET AND NUMBER: 347 BALTIMORE AVE. | | | |
| 14. FATHER'S NAME First: JAMES | Middle: F | Last: BANZHOF | 15. MOTHER'S MAIDEN NAME First: MYRTLE Middle: J Last: MEYERS |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes | (If yes give war or dates of service): WW 1 | 16b. SOCIAL SECURITY NO.: 213-12-9215 | 17. INFORMANT Address: MEMORIAL HOSP., CUMBERLAND, MD. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Adeno carcinoma Lung Rt. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Carcinomatosis liver - Retro Peritneal Glands

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from April, 1968, to Aug, 1969, that (I) (~~we~~) last saw the deceased alive on 19 Aug 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Fuller B Whitworth MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 20 Aug 69

22d. PHYSICIAN'S NAME (Type): DR. FULLER WHITWORTH

22e. ADDRESS: CUMBERLAND, MD.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 8/22/1969 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park | 23d. LOCATION (City or Town): Near Cumberland | (County): Alleg (State): Md |
| 24. FUNERAL DIRECTOR: John J. Hafer, Jr. | ADDRESS: 230 Balto Ave. Cumberland Md | 25a. RECD BY REGISTRAR DATE: AUG 25 1969 | 25b. REGISTRAR'S SIGNATURE: [illegible] Judge | |

VR A15 (4)
45M - 1-69

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

10701

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10698

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| John | R. | Basile | Aug. | 8 | 1969 | 9a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN | 2c. DATE PRONOUNCED DEAD Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | March 14, 1891 | 78 YRS. | | | | | Aug. | 8 | 1969 | 9a M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Italy | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Sacred Heart Hospital | Shoe Rebuilder | Shoe Shop |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Cumberland | YES ☒ NO ☐ | 150 N. Mechanic St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Antonio | | Basiel | Aquila | | Greco |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | War I | 212-32-8190 | Frank Basile, Pleasantville, N.Y.-Brother |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Cumberland, Md.

22b. DATE SIGNED Aug. 8, 1969

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 12, 1969 | St. Mary's Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | AUG 13 1969 | Charles Judge |

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10702

# CERTIFICATE OF DEATH

10699

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| EUGENE | E. | BECKWITH | 8 | 1 | 69 | 1:15 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | 5-17-09 | 60 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNA. | U.S. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | Salesman WOLF FURN. CO. | FURNITURE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 210 SARATOGA ST., |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| LAWRENCE | | BECKWITH | OLIVE | | FLOOD |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 191-10-4452 | Mrs. Dorothy L. Beckwith WIFE - 210 SARATOGA ST., CUMB., MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC AND RENAL FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(b) ESOPHAGEAL VARICIES
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4560

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 7-16-69 | ESOPHAGEAL VARICIES | YES [ ] NO [X] | YES |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 7-8-69, 19___, to 8-1-69, 19___, that (I) (we) last saw the deceased alive on 8-1-69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED |
|---|---|---|---|
| M. Matthew L Kaufman | MD | | 8-1-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| M.L..KAUFMAN, M.D. | 900 SETON DRIVE SACRED HEART HOSP., CUMB., MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8-4-69 | Woodlawn Cemetery | Milroy, Mifflin Penna. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George 202 Greene St. Cumberland, Md. | AUG 4 1969 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

10202

Item #5 taken from birth certif. 8/13/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10703

10700

## CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| James | Allen | BENTON | 8 | 3 | 69 | 4:15A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | 8-2-~~00~~ 69 | — YRS. | | | 9 | 28 |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | None, infant | None |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland. | Carroll | Sykesville | YES ☒ NO ☐ | Gaither Manor Apts. Apt. 4-101 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| ALLEN | | BENTON | JANICE | L. | LEARY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| | | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hepatic membrane — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 - 10 hrs

DUE TO, OR AS A CONSEQUENCE OF (b) Congestion of liver

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last. 7761

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot (I) (this hospitol) attended the deceased from 8/2, 1969, to 8/3, 1969, thot (I) (we) lost sow the deceased alive on 8/3 1969, and thot in (my) (our) opinion deoth occurred on the dote and hour and from the couses stoted above, (I) (we) (did) (did not) view the body after deoth.

| 22b. SIGNATURE | •DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| DR. R. Hodges, M.D. | | ☒ | ☐ | ☐ | Aug. 9, 1969 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. R. HODGES | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/4/69 | Hillcrest Burial Park | Cumberland, Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George Cumberland, Md. | AUG 11 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4-45M - 7-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10704 10701

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| JACOB | L. | BIGGS | AUGUST 30 1969 | 1:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 12-3-82 | 86 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| WEST VIRGINIA | UNITED STATES | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | MEMORIAL HOSPITAL | ENGINEER | RAILROAD |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W.VA. | MINERAL | RIDGELEY | YES [X] NO [ ] | 111 MAIN ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JACOB | | BIGGS | MARIA | | KIGHT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 705 09 9948 | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Arter S
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arter Sclerosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 7/16/69, 19____, to 8/30/69, 19____, that (I) (we) last saw the deceased alive on 8/28/69, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| | MD | [X] | [ ] | [ ] | 8/31/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. R.J. WILLIAMS | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | SEPT. 2, 1969 | ROSE HILL CEMETERY | CUMBERLAND, MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| BYRON KIGHT | CUMBERLAND, MD. | SEP 2, 1969 | |

VR A15 (1)
45M - 1-68

1

10705

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10702

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (3-69)
45M - No. 68

| | | | | |
|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: ADA | Middle: S. | Last: BRENNEMAN | 2o. DATE OF DEATH Month: 08 Day: 11 Year: 69 | 2b. HOUR: 1:05 AM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 09-20-78 | 6. AGE (In years last birthday): 90 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7o. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY | Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housekeeper | 12b. KIND OF BUSINESS OR INDUSTRY: None | |
| 13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission): MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 217 GLEN STREET |
| 14. FATHER'S NAME First: CHARLES | Middle: | Last: Swauger | 15. MOTHER'S MAIDEN NAME First: ALICE | Middle: | Last: GREEN |
| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown: NO | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 220-28-9457 | 17. INFORMANT: HOSPITAL REC. | Address: 900 SETON DR., CUMBERLAND, MD. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 y

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerosis — 10 y

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Senility

| | | | |
|---|---|---|---|
| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20o. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22o. **I certify** that (I) (this hospital) attended the deceased from 8/1, 19 69, to 8/12, 19 69, that (I) (we) last saw the deceased alive on 8/11 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | |
|---|---|---|---|---|
| 22b. SIGNATURE: A.L. Meneeley | DEGREE: MD | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 8/13/69 | |
| 22d. PHYSICIAN'S NAME (Type): DR S G WEITZMAN B.M. SCHINDLER MD ON VACATION | 22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD. | | | |

| | | | |
|---|---|---|---|
| 23o. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 8/14/69 | 23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park | 23d. LOCATION (City or Town) (County) (State): Frostburg Allegany Maryland |
| 24. FUNERAL DIRECTOR: COLCOX FUNERAL HOME Merritt- | ADDRESS: 404 DECATUR ST., CUMBERLAND, MD. 21502 | 25o. REC'D BY REGISTRAR DATE: AUG 11 1969 | 25b. REGISTRAR'S SIGNATURE: Glenda Judge |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10706 — 10703

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Evelyn | Middle: Gertrude | Last: Broadwater | 2a. DATE OF DEATH: Month 8 Day 2 Year 1969 | 2b. HOUR: 530PM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: 11-14-98 | 6. AGE (In years last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Cumberland Nursing Center | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Barton | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER: None | |
| 14. FATHER'S NAME First: Nelson | Middle: | Last: Broadwater | 15. MOTHER'S MAIDEN NAME First: Virginia | Middle: | Last: Broadwater |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give wor or dates of service) | 16b. SOCIAL SECURITY NO.: 217-01-1395 D | 17. INFORMANT: Son Donald Broadwater | Address: Midland, Md. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO, OR AS A CONSEQUENCE OF
(b): Carcinoma of colon (resected) — 3 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote | |

22a. **I certify** that (I) (this haspital) attended the deceased from 5-20, 1969, to 8-2, 1969, that (I) (we) last saw the deceased alive an 8-2 1969, and that in (my) (aur) apinfan death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Vaiher P. Dross — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 8-3-69 | | |
| 22d. PHYSICIAN'S NAME (Type): V.P. Dross | 22e. ADDRESS: Cumberland, Md. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Buried | 23b. DATE: 8/5/69 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. View | 23d. LOCATION (City or Town): Moscow Mills (County) Md. (State) | |
| 24. FUNERAL DIRECTOR: E. L. Bra | ADDRESS: Westernport, Md. 21562 | 25a. RECD BY REGISTRAR DATE: AUG 5 1969 | 25b. REGISTRAR'S SIGNATURE: [illegible] Judge | |

VR A15 (R) 45M - 69

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10707

10704

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| HAROLD | E | BROWNE | 8 | 22 | 69 | 8 25 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | 8-26-98 | 70 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | B. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| NEW YORK | USA | MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | ALLEGAHNAY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | CUMBERLAND NURSING HOME | BANKER & REAL ESTATE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | Allegany | LA VALE | YES ☒ NO ☐ | 606 N 3RD STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| DUDLEY | P | BROWN | ELLEN | L | BENNETT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| YES | WWII | | DUDLEY BROWNE | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

342 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | cardiac arrest | minutes. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | acute renal insufficiency | appox. 4 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Parkinsons Disease | years. |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Senility & Chr. Brain Syndrome

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this haspital) attended the deceased from 8-14, 1969, to 8-22, 1969, that (I) (we) last saw the deceased alive an 8-22 1969, and that in (my) (aur) opinian death occurred on the date and haur and from the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John K. Tepper MD | MD | ☒ | ☐ | ☐ | 8-23-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| John K. Tepper MD | Memorial Hospital Cumberland, Md |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Cremation | 8/26/69 | Bernhaus Crematory | Pittsburg Penna. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Louis Stein Inc. | Cumb. Md. | AUG 26 1969 | Miranda Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 haurs after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10708

# CERTIFICATE OF DEATH

10705

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2o. DATE OF DEATH Month | Doy | Yeor | 2b. HOUR |
|---|---|---|---|---|---|---|
| LOUISE | F. | CATON | 08 | 17 | 69 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In yeors last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN |
|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | APRIL 19, 1891 | 78 YRS. | | | | |

| 7o. BIRTHPLACE (Stote or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | MINERS HOSPITAL | HOUSE WIFE | |

| 13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | | 55 BROADWAY |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| CHARLES | | FINZEL | MOLLIE | | FESTERMAN |

| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 218-05-1527A | DOROTHY NORTON | 78 LOCUST ST. FROSTBURG |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
Conditions, if ony, which gove rise to immediote couse (o); stoting the underlying couse lost.

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (o) | ACUTE BRAIN SYNDROME 437.9 | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CIRCULATORY DISTURBANCE | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | CEREBRAL ARTERIOSCLEROSIS | 2 hrs. |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20o. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from AUG 11, 19 69 to AUG. 17, 19 69, that (I) (we) last saw the deceosed alive on AUG. 16 19 69 and that in (my) (our) apinion deoth occurred on the dote and hour ond from the causes stated obave, (I) (we) (did) (did nat) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| C. Paige Strong, M.D. | | ☒ | ☐ | ☐ | Aug. 17, 1969 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| A. PAIGE STRONG, MD | 167 E. MAIN ST. FROSTBURG, MD. |

| 23o. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| BURIAL | 8-19-69 | FINZEL CEMETERY | FINZEL | ALLEGANY | MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25o. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| JOSEPH R. DURST SR. | FROSTBURG, MD. | AUG 21 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10709

10706

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month | Day | Year | 2b. HOUR | | | |
| | J. | WALKER | CHAPMAN | X | Aug. | 27, | 1969 | 3p M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD Month | Day | Year | 2d. HOUR |
| MALE | WHITE | JULY 24, 1893 | 76 YRS. | | | | | August | 28, | 1969 | 9 a M |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH | | | | | | | | |
| MARYLAND | U.S.A. | | ALLEGANY Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| FROSTBURG | ROUTE 1 | RETIRED SUPERVISOR-STATE RD. DEPT. | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | | | | | |
| MARYLAND | ALLEGANY | FROSTBURG | YES ☐ NO X | ROUTE 1 | | | | | | | |
| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last | | | | | | |
| JAMES | | CHAPMAN | MARGARET | | KEIR | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS | | | | | | | |
| YES | WW 1 | 213-03-5213 | JEFFREY CHAPMAN, RT. 1, | FROSTBURG, MD. 21532 | | | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | --- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO X |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry XX, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

ADDRESS(Street, city, town, or county)

22b. DATE SIGNED August 28, 1969

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR ~~CREMATORY~~ | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 8-30-1969 | FROSTBURG MEMORIAL | FROSTBURG, ALLEG, MD |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | SEP 2 1969 | Charles Inge |

VR A15ME (5) 10M REV. 1/68

10709

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10710

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10707

# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: GEORGE | Middle: P. | Last: CLARK | 2a. DATE OF DEATH: 08 Month 01 Day 69 Year | 2b. HOUR: 11:50A M | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 10-10-86 | 6. AGE (In years last birthday): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY COUNTY Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, MD. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PA. | 13b. COUNTY: ~~Bedford~~ | 13c. CITY OR TOWN: HYNDMAN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: ROUTE #1 | | |
| 14. FATHER'S NAME First: JOHN | Middle | Last: CLARK | 15. MOTHER'S MAIDEN NAME First: MARY | Middle | Last: PRESSMAN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-20-6578 | 17. INFORMANT: MEMORIAL HOSPITAL | Address: CUMB. MD. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinomas — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO, OR AS A CONSEQUENCE OF
(b): Carcinoma of colon — 3 months
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 153.8

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
arteriosclerosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. **I certify** that (I) (this hospital) attended the deceased from 7-27, 19 69, to 8-1, 19 69, that (I) (we) last saw the deceased alive on 8-1 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Vasilios P. Dross | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 8-3-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. V. DROSS | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 4, 1969 | German Beneficial Cty. | Cumberland, Allegany Co. Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Harvey H. Zeigler, Hyndman, Pennsylvania | AUG 7 1969 | Charles Judge |

VR A 15 (4)
45M - 1-69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10711

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10708

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN ☐ OF DEATH ESTIMATED ☐ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| JOHN | HAYDN | DAVIES | August 7, 1969 | 5 a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS HOURS | IF UNDER 24 HRS MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| Male | White | 12/23/1900 | 68 YRS. | | | | | August 7, 1969 | 10 a M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ## | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | 110 Bedford Street | Kelly Springfield Tire Co. | Tires. |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ## NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | | 110 Bedford Street. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | HAYDN | DAVIES | | | DONALDSON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT deputy ADDRESS |
|---|---|---|---|
| NO | | | MEDICAL EXAM. CUMBERLAND MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Coronary Occlusion, left | Sudden |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Thrombosis | " |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Coronary Sclerosis | --"-- |

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED AUGUST 7, 1969

ADDRESS(Street, city, town, or county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/9/69 | Hillcrest Burial Pk. | Cumb. Allegany Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Lowe's Steri Inc. | Cumb Md | AUG 11 1969 | Charles Judge |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farworded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME(5)
10M REV. 1-68

5-1

FOR STATE HEALTH DEPT.

10712

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10709

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Alva | Middle: Wellington | Last: Davis | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ | Month: Aug. | Day: 17 | Year: 1969 | 2b. HOUR: 4:30 P.M. |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: May 13,1891 | 6. AGE (In years last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | 2c. DATE PRONOUNCED DEAD: Month Aug. Day 17 Year 1969 | | 2d. HOUR: 4:30 P.M. |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): D.O.A. Memorial H. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Blacksmith | 12b. KIND OF BUSINESS OR INDUSTRY: Railroad | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 1003 Virginia Ave. | | | | |
| 14. FATHER'S NAME: First Stephen | Middle E. | Last Davis | 15. MOTHER'S MAIDEN NAME: First Ida | Middle Piper | Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. Zena Davis, | ADDRESS: Cumberland, Md.-Wife | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | -- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr.Benedict Skitarelic,MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS(Street, city, town, or county): Cumberland, Md.

22b. DATE SIGNED: Aug. 17, 1969

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug.20,1969 | Rose Hill Cemetery | Cumberland,Allegany,Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | AUG 19 1969 | Charles Judge |

VR A15ME (5)
10M REV. 1/68

1 B

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10713

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10710

| 1. DECEASED-NAME (Type or Print) | First | Middle | Last |
|---|---|---|---|
| | Calvin | Robert | Davis |

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ Month Day Year: Aug. 27, 1969 — 2b. HOUR: 6 p M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | May 18, 1926 | 43 YRS. | | | | |

2c. DATE PRONOUNCED DEAD: Month August Day 28, 1969 Year 19 — 2d. HOUR: 10 a M

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Barton | | Laborer | Paper Mill |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Barton | YES ☐ NO ☒ | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Edward | | Davis | Sylvia | | Farris |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | WW 2 | 215 26 7587 | Beauannis Davis | Westernport, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Shattered Head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) Gunshot (self-inflicted) — "

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 955X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: August 28, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/31/69 | Philos Cem. | Westernport Allegany Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| E. L. Boal | Westernport, Md. | SEP 2 1969 | Wm. Lemley Judge |

10513

1

10714

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10711

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print): First JOSEPH; Middle THOMAS; Last DEVLIN
2a. DATE OF DEATH: Month 08 Day 11 Year 69
2b. HOUR: 1:10 AM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 08-18-07
6. AGE (In years last birthday): 61 YRS.
IF UNDER 1 YEAR: MONTHS; DAYS
IF UNDER 24 HRS.: HOURS; MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RUBBER WORK
12b. KIND OF BUSINESS OR INDUSTRY: KELLY TIRE CO.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission): STATE MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: LA VALE
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 1064 NATIONAL HWY.
14. FATHER'S NAME: First TERRANCE; Middle; Last DEVLIN
15. MOTHER'S MAIDEN NAME: First NANNIE; Middle; Last ;SIMONS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknown): NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 216-05-5309
17. INFORMANT Address: HOSPITAL REC., 900 SETON DR., CUMBERLAND, MD.

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute tracheo-bronchitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12-18 hrs
447X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Bilat. lumbar Sympathectomy — on July 31/69
DUE TO, OR AS A CONSEQUENCE OF (c): Occlusive arterial dis both legs — Several M.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chr. alcoholism (for yrs)
19a. DATE OF OPERATION: 7/31/69
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: as above (A.S.)
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: F. W. Miltenberger MD — DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 8-11-69
22d. PHYSICIAN'S NAME (Type): F.W. MILTENBERGER MD — F.W. Miltenberger per D. Morton MD
22e. ADDRESS: 122 S. CENTRE ST. CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8/13/69
23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery
23d. LOCATION (City or Town) (County) (State): Lonaconing A. Md
24. FUNERAL DIRECTOR ADDRESS: EICHHORN FUNERAL HOME, 8 E. MAIN ST., LONACONING, MD.
25a. REC'D BY REGISTRAR DATE: AUG 13 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (1)
45M - 9-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10715

10712

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: RUSSELL | Middle: C. | Last: DIEHL | 2a. DATE OF DEATH: Month AUG. Day 21 Year 1969 | | 2b. HOUR: M |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: JULY 8, 1891 | 6. AGE (In years last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country): PENNA. | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH: FROSTBURG | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MINERS HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): OFFICE MANAGER - C&P TELEPHONE CO. | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: FROSTBURG | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 120 FROST AVENUE | | |
| 14. FATHER'S NAME First: MICHAEL | Middle | Last: DIEHL | 15. MOTHER'S MAIDEN NAME First: ELIZABETH | Middle | Last: DIEHL | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 212-05-0780 | 17. INFORMANT: MRS. ADA DIEHL, | Address: FROSTBURG, MD. 21532 | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute brain syndrome

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 437.9

DUE TO, OR AS A CONSEQUENCE OF (b): Circulatory disturbance

DUE TO, OR AS A CONSEQUENCE OF (c): Cerebral arteriosclerosis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pneumonitis left lung-diabetes mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this haspital) attended the deceased from Aug. 8, 19 69, to Aug. 21, 19 69, that (I) (we) last saw the deceased alive an Aug. 21 19 69 and that in (my) (aur) apinian death occurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: G. Paige Strong | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 8/22/69 | |
| 22d. PHYSICIAN'S NAME (Type): A. PAIGE STRONG, M. D. | 22e. ADDRESS: 167 E. MAIN ST., FROSTBURG, MD. 21532 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: AUG. 24, 1969 | 23c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEMETERY | 23d. LOCATION (City or Town): CUMBERLAND, | (County): MD. (State) |
| 24. FUNERAL DIRECTOR: JOSEPH R. DURST, | ADDRESS: FROSTBURG, MD. 21532 | 25a. REC'D BY REGISTRAR DATE: AUG 29 1969 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | |

VR A15 (3) 45M - 1/69

10715

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Item23 FilmG416
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# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10716

10713

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| James | Edmund | Dougherty | ☐ ☐ | Aug. | 20 | 1969 | 8:15 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD: Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | Oct.1, 1940 | 28 YRS. | | | | | Aug. | 20 | 1969 | 9p M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| La Vale, Md. | 103 Holly Ave. | Pipefitter | Construction |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | La Vale | YES ☒ NO ☐ | 103 Holly Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Emmett | A. | Dougherty | Iva | | Donoughe |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Yes | 212-38-6188 | Mrs. Sherry Dougherty, La Vale, Md.-Wife |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot of head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF (b) (Self-inflicted)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 955 X

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Cumberland, Md.

22b. DATE SIGNED: Aug. 20, 1969

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | Aug.23,1969 | St.Peter& St.Paul Cemetery | Cumberland | | Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | AUG 22 1969 | J Charles Judge |

VR A15ME (5) 10M REV. 1/68

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10717

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10714

# CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Bertha | Inez | Duckworth | 8 | 16 | 69 | 740A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| Female | White | 2-8-92 | 77 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W.VA. | USA | WIDOWED ☒ | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Cumberland Nursing Center | Housewife | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES / NO | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| WVA. | Hampshire | Springfield | YES ☒ NO ☐ | None |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Lucius | K. | Hinkle | Unknown | | Garland |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 234-78-8383 | Thelma Puffinburger, | Greenspring, WVa |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypostatic pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks.

4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral thrombosis — 6 mnths

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 3-24-69, 19 69, to 8-16, 19 69, that (I) (we) last saw the deceased alive on 8-15 19 69, and that in (my) (our) opinion death occurred on the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| P B Halmos | MD | ☒ | ☐ | ☐ | 8/16/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| P. B. HALMOS | 302 SCHLEY ST, CUMBERLAND |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 19, 1969 | Springfield Hill Cem. | Springfield Hampshire W.Va. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Ralph Stotler | Romney W.Va. | AUG 21 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

10718

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10715

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: ARTIE | Middle: B. | Last: DURRETT | 2a. DATE OF DEATH: Month AUGUST, Day 6, Year 1969 | 2b. HOUR: 4:54 P | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 11-8-84 | 6. AGE (In years last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): W. VA. | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 316 WILLIAMS ST., | | |
| 14. FATHER'S NAME First: BURR | Middle: | Last: STEVENSON | 15. MOTHER'S MAIDEN NAME First: AMANDA | Middle: | Last: SMITH | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. | Address | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive A. D. Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. **I certify** that (I) (this hospital) attended the deceased from 7-17-, 1969, to 8-6-, 1969, that (I) ~~(we)~~ last saw the deceased alive on 8-6-1969 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| W. F. Williams | | ☒ | ☐ | ☐ | 8-7-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W.F.WMS. | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 9, 1969 | Hillcrest Burial Park | Cumberland, Allegany, Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. DATE RECEIVED BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | AUG 11 1969 | |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M · 69

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10719

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10716

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| DAVID M. | M. | EAVENSON | 08 | 11 | 69 | 12:46 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 08-09-69 | — YRS. | 2 | 44 / 3 |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | NEVER MARRIED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | SACRED HEART HOSPITAL | NONE | NONE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND W. Va. | ALLEGANY Preston | CUMBERLAND Albright | YES [X] NO [ ] | 407 BEDFORD STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| ROBERT | | EAVENSON | SUE | A. | BISHOP |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NON | NONE | HOSPITAL REC., CUMBERLAND, MD. 21502 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Anoxia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4/4 hours

766.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Difficult Delivery 2° to Breech — 4/4 hours

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Atelectasis of right upper Lobe

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [X] NO [ ] | NO |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OEFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased fram _____, 19____, ta _____, 19____, that (I) (we) last saw the deceased alive an _____ 19____, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Gary A. Fleming, M.D. | | [X] | [ ] | [ ] | 8/11/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| GARY A. FLEMING, M.D. | 500 Greene Street, Cumberland, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug 12 1969 | Maplewood Cemetery | Kingwood Preston W.Va. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| BROWNING FUNERAL HOME, KINGWOOD, W. VA. | AUG 14 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10720

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10717

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| AMOS | R | FELKER | AUGUST 23 1969 | 7:00 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 11-22-1899 | 69 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | MINER | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [ ] NO [X] | ROUTE 2, BOX 22 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| CONRAD | | FELKER | ISABELLA | | KEEFER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 216-10-4514 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrythmia

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Severe pulmonary emphysema & fibrosis, Ruptured bleb

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | Left Pneumothorax |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 8-20-, 1969, to 8-23-, 1969, that (I) ~~(we)~~ last saw the deceased alive on 8-23- 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Wm. F. Williams | | | [X] | [ ] | 8-25-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W. F. WILLIAMS | 122 S. CENTRE ST., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | AUG. 26 '69 | ECKHART CEMETERY | ECKHART, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | AUG 29 1969 | Charles Judge |

VR A15
45M - 1-69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10721

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10718

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH / ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| Hugo | H | Fickenscher | | 8 | 3 | 1969 | 10a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month / Day / Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | White | 8/7/1891 | 77 YRS. | | | 8 / 3 / 19 69 | 10a M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| New York | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | 508 Shriver Avenue | Ministry- Lutheran | Church |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES [X] NO [ ] | 508 Shriver Avenue |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| George | W | Fickenscher | Margaret | | Rang |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 214-24-1448 | Mrs. Richard Hobrock | 508 Shriver Ave Cumberland, Md |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | -- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | | |

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X] Inquiry [X], and in my opinion death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: August 3, 1969

ADDRESS(Street, city, town, or county): Cumberland, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | AUG. 6, 1969 | GREENLAWN BURIAL ESTATES | BUTLER BUTLER PENNSYLVANIA |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Silcox-Merritt Funeral Service. Cumberland, Md 21502 | AUG 5 1969 | Charles Judge |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death unless delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ... Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10722 10719

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Frank | Middle: | Last: Fiorita | 2a. DATE OF DEATH Month: 8 Day: 13 Year: 69 | 8:35 A. M. | 2b. HOUR |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: April 14, 1885 | 6. AGE (In years last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country): Naples | 7b. CITIZEN OF WHAT COUNTRY?: Italy | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany County | | | Md. |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Coal Miner | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Frostburg | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: P.O. Box 290 | | |
| 14. FATHER'S NAME First: [illegible] San | Middle: | Last: Fiorita | 15. MOTHER'S MAIDEN NAME First: Catherine | Middle: | Last: Fiorita | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-16-2574 | 17. INFORMANT: P.O.Box 599, Cumberland, Maryland Allegany County Infirmary records. | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: approx. 1/2hr.
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerosis — many years.
DUE TO, OR AS A CONSEQUENCE OF (c): Chr. A.S. Hyp. C.V.D — many years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
B.P.H. Diabetes Mellitus. Reactive Depression. Senility.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. **I certify** that (I) (this haspital) attended the deceased from June 6, 19 69, ta August 13, 19 69, that (I) (we) last saw the deceased alive an August 12, 19 69, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [X] STAFF PHYS. [X] | 22c. DATE SIGNED |
|---|---|---|
| John A. Topper | | 8. 13 69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| John A. Topper | Memorial Hospital Cumberland Md |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 16, 1969 | St. Michael's Cemetery | Frostburg, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Joseph R. Durst, Frostburg, Md. 21532 | AUG 16 1969 | Charles Judge |

FOR STATE HEALTH DEPT.

10723

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10720

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: CLARENCE | Middle: FLOYD | Last: FISHEL | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month: August Day: 12 Year: 69 | 2b. HOUR: 8a M | | | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Jan. 12, 1913 | 6. AGE (In years last birthday): 56 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month: AUGUST Day: 12, 1969 Year 19 | 2d. HOUR: 8a M | | | | |
| 7a. BIRTHPLACE (State or foreign country): W,Va. | 7b. CITIZEN OF WHAT COUNTRY?: U. S. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Machinist | 12b. KIND OF BUSINESS OR INDUSTRY: B&O R.R. | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W,Va. | 13b. COUNTY: Hampshire | 13c. CITY OR TOWN: Greenspring | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: Rural | | | | | |
| 14. FATHER'S NAME: First: Jacob Middle: Last: Fishel | 15. MOTHER'S MAIDEN NAME: First: Minnie Middle: Last: Windfield | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 705-05-1680 | 17. INFORMANT: Roland D. Fishel, ADDRESS: Greenspring, W,Va. | | | | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY THROMBOSIS, LEFT | SUDDEN |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 — DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | -- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [XX] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22b. DATE SIGNED: AUGUST 12, 1969
ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 15, 1969 | Forest Glen | Greenspring, Hampshire W,Va. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| [signature] | Romney, W,Va. | AUG 15 1969 | Charles Judge |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10724

# CERTIFICATE OF DEATH

10721

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: STEPHANIE | Middle: ANN | Last: GARLITZ | 2a. DATE OF DEATH Month: 08 Day: 10 Year: 69 | 2b. HOUR: 12:45 M |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 10-31-68 | 6. AGE (In years last birthday): YRS. | IF UNDER 1 YEAR: Months: 09 Days: 10 | IF UNDER 24 HRS.: Hours / Min. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, MD. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE | 12b. KIND OF BUSINESS OR INDUSTRY: NO NE | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission): STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: LaVale | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 5 BANE ST. | |
| 14. FATHER'S NAME First: MICHAEL | Middle: A. | Last: GARLITZ | 15. MOTHER'S MAIDEN NAME First: ANNA | Middle: | Last: AKERS |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: NONE | 17. INFORMANT: Michael A. Garlitz | Address: 5 Bane St. LaVale, Md. | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Anoxia | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 330.2 — DUE TO, OR AS A CONSEQUENCE OF (b) | Pneumonitis - 2° Aspiration | 2 days. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Amyotonia Congenita | 9 mo |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote | |

22a. **I certify** thot (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, thot (I) (we) last saw the deceased olive on _____ 19____, and thot in (my) (aur) opinian deoth occurred on the date ond hour ond from the causes stated abave, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: Robert D Brodell | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED: 8/10/69 |
| 22d. PHYSICIAN'S NAME (Type): ROBERT BRODELL MD | | 22e. ADDRESS: 500 GREENE ST., CUMBERLAND, M.D. | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 8/12/69 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park, | 23d. LOCATION (City or Town): Cumberland, | (County): Allegany (State): Md. |
| 24. FUNERAL DIRECTOR: GEORGES FUNERAL H. | ADDRESS: Wayne George Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: AUG 14 1969 | 25b. REGISTRAR'S SIGNATURE: Rhonda Yonger | | |

VR A15 (4) 45M - 1-68

1

10725

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10722

1. DECEASED-NAME (Type or print): First Charles Middle Andrew Last Glessner
2a. DATE OF DEATH: Month 12 Day 6 Year 69
2b. HOUR: 8 AM/PM
3. SEX: M
4. RACE: White
5. DATE OF BIRTH: Aug. 14, 1884
6. AGE (In years last birthday): 85 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Berlin Pa
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Allegheny Md.
10. CITY OR TOWN OF DEATH: Bumberland Md
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Cumberland Nursing Center
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Steam Master
12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Rt #1 Box 189
13b. COUNTY: Allegheny
13c. CITY OR TOWN: Cumberland Md
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: Rt #1 Box 189
14. FATHER'S NAME First Agustus Middle Last Glessner
15. MOTHER'S MAIDEN NAME First Agnes Middle Last Ross
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No
16b. (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 200 07 2108
17. INFORMANT: Mrs Clair Bloom Address: Rt 1 Box 189 Cumberland Md

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Congestion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO, OR AS A CONSEQUENCE OF
(b): Cardiovascular Heart disease — many years
DUE TO, OR AS A CONSEQUENCE OF
(c):

4124
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Fractured right hip

19a. DATE OF OPERATION: 6-9-69
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month 6 Day 8 Year 1969
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Fell out of bed
21d. INJURY OCCURRED While at work ☐ Not while at work ☒
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Memorial Hospital
21f. LOCATION Street or R.F.D. No. City or Town: Cumberland County: State:

22a. I certify that (I) (this hospital) attended the deceased from 6-5-69, 19___, to 7-12, 1969, that (I) (we) last saw the deceased alive on 7-12-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Robert Feddis DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 12 Aug 69
22d. PHYSICIAN'S NAME (Type): ROBERT FEDDIS
22e. ADDRESS: 500 GREENE

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Aug 15, 1969
23c. NAME OF CEMETERY OR CREMATORY: Somerset C. Mem. Park
23d. LOCATION (City or Town) (County) (State): Somerset Somerset Pa.
24. FUNERAL DIRECTOR: Don J Newman ADDRESS: Grantsville Md.
25a. REC'D BY REGISTRAR DATE: AUG 18 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, give the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

10726

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10723

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| HARRY | G. | GRAY | 8 30 69 | 8:55AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 4-3-83 | 86 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNA. | UNITED STATES | NEVER MARRIED (X) | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | RETIRED | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| PENNA. | | HYNDMAN | YES / NO (X) | ROUTE 1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| ALEX | | GRAY | ANNIE | | SUTER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | | 190-16-2231 | HOSPITAL RECORD | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Emphysema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last. 492X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pulmonary + Arteriosclerotic Heart Disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES / NO | |

| 21a. ACCIDENT WAS UNDERLYING (If either, natify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| OR CONTRIBUTING / CAUSE OF DEATH | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote |
|---|---|---|
| | | |

22a. **I certify** that (I) (this haspital) attended the deceased from 2/27, 19 69, to 8/30, 19 69, that (I) (we) last saw the deceased alive on 8/30 19 69, and that in (my) (aur) opinian death occurred on the date and haur and fram the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| S G Weisman | MD | (X) | | | 9/1/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| S G WEISMAN MD | 59 GREENE ST CUMBERLAND MD |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | September 1, 1969 | Comps Cemetery | Hyndman, Bedford, Pa. RD |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECEIVED BY REGISTRAR, DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| ZIEGLER FUNERAL HOME, HYNDMAN, PENNA. | SEP 4 1969 | Charles Judge |

VR A15 (4)
45M - 1/69

10727

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

Item5 Film G115 8/19/69 kk

10724

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| CORA | B. | GRIFFITH | AUGUST | 11 | 1969 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| FEMALE | WHITE | 1/18/1879 AUGUST 11, 1969 | 90 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | MINERS HOSPITAL | HOUSE WIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES ☒ NO ☐ | 90 BOWERY STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GEORGE | | RICHARDSON | ROSE ANN | | McDONALD |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | | MRS. CHAS. FRANKENBERRY, FROSTBURG, MD. 21532 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease — 2 hours

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Intertrochanteric fracture left hip

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. X P.M. Month Day Year | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | 7-3 19 69 | Slipped and fell in home |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☒ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | Home | 90 Bowery Street, Frostburg, Md. |

22a. **I certify** that (I) (this hospital) attended the deceased from 7/4, 19 69, to 8/11, 19 69, that (I) (we) last saw the deceased alive on 8/10 1969, and that in (my) (aur) opinian death accurred an the dote and haur and from the causes stated above, (I) (we) (did) (did not) view the body ofter death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| G Paige Strong MD | | | | | 8/12/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| A. Paige Strong, M.D. | 167 E. Main, Frostburg, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | AUG. 14, 1969 | FBG. MEMORIAL PARK | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | AUG 14 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
45M - 1-68

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10728

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10725

## CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH | 2b. HOUR |
|---|---|---|---|---|
| JOHN | WILLIAM | GROVES | 8 Month 24 Day 69 Year | 9:20 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (If years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 06 24 89 | 80 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | WIDOWED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | BARBER | Self Emp. |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY | CUMBERLAND | YES X NO | REAR 226 HARRISON STREET |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| Harry P. Groves | Lucy [illegible] Topp |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 220 16 6271 | SACRED HEART HOSPITAL -900 SETON DRIVE CUMBERLAND |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CONGESTIVE HEART FAILURE | 8 MOS |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ACVD | 2 YEARS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

DIABETES MELLITUS

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5-6-67, 19__, to 8-24-69, 19__, that (I) (we) last saw the deceased alive on 8-24-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Ralph L. Ballin | M.D. | X | ☐ | ☐ | 8-25-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. R.W. BALLIN | 62 GREENE STREET -CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 27, 1969 | SS. Peter & Paul Church | Cumberland, Allegany, Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SCARPELLI FUNERAL HOME -108 VA AVENUE- BUMB, MD | AUG 28 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

10729

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10726

## CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| ROY | WILLIAM | HAMMOND | 08 | 14 | 69 | 1:15 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 09 10 09 | 59 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY CO., Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSP. | TRUCK DRIVER | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FLINTSTONE | YES [ ] NO [X] | STAR ROUTE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| SAMUEL | E. | HAMMOND | (BOWERS) CARRIE | B. | HAMMOND |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | | 214 05 8756 | PATIENT'S HOSPITAL CHART | 900 SETON DRIVE CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinomatosis of brain | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carcinoma of Lung | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Aug 1, 1969, to Aug 14, 1969, that (I) (we) last saw the deceased alive on Aug 14 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | | [X] | [ ] | [ ] | 8/16/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. WEISMAN | 59 GREEN ST., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/17/69 | Buck Valley Memorial Cem. | Bedford County, Penna. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| HAFER FUNERAL HOME Charles E. Hafer | 230 BALTIMORE AVE. CUMBERLAND, MD. | AUG 19 1969 | [signature] Registrar Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

10729

ROY WILLIAM HAMMOND 08 14 69 1:15P

MALE WHITE 09 10 00 50

X

MARYLAND U.S.A. ALLEGANY CO.,

CUMBERLAND SACRED HEART HOSP. TRUCK DRIVER

MARYLAND ALLEGANY FLINTSTONE X STAR ROUTE

SAMUEL E. HAMMOND (BOWERS) CARRIE B. HAMMOND

900 SETON DRIVE

NO 214 05 8755 PATIENT'S HOSPITAL CHART CUMBERLAND, MD.

DR. WEISMAN 59 GREEN ST., CUMBERLAND, MD.

Buck Valley Memorial Cem. Bedford County, Penna.

HAFER FUNERAL HOME 230 BALTIMORE AVE.
CUMBERLAND, MD.

FOR STATE HEALTH DEPT.

10730

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10727

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| Betty | Lou | Hansell |

2a. DATE KNOWN OF DEATH ESTIMATED ☒ Month Day Year: AUGUST 9, 1969 — 2b. HOUR: 5:45 P M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | July 13,1933 | 36 YRS. | | |

2c. DATE PRONOUNCED DEAD Month AUGUST Day 9, Year 1969 — 2d. HOUR: 5:45 P M

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| W.Va. | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | MEMORIAL HOSPITAL--DOA | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Cumberland | YES ☒ NO ☐ | 613 E. Oldtown Road |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| Arthur B. Parsons | Hazel Dumire |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | | Husband Mr. Howard V. Hansell, Cumberland, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | INTRACRANIAL HEMORRHAGE..... | Hours |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (b) | RUPTURE OF BERRY ANEURYSM.... | - |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) | (CONGENITAL) | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4309

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | | |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: AUGUST 9, 1969

ADDRESS (Street, city, town, county, state): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug.12,1969 | Davis Memorial Cemetery | Cumberland, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | AUG 13 1969 | Charles Judge |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10731

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10728

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| GEORGE | W. | HENDRICKSON |

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month 8 Day 27 Year 69 — 2b. HOUR 7 PM

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | FEB. 26, 1881 | 88 YRS. | | | | |

2c. DATE PRONOUNCED DEAD: Month Aug. Day 27 Year 1969 — 2d. HOUR 7 PM

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | 715 MARYLAND AVENUE | SECRETARY | YMCA |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 715 MARYLAND AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GEORGE | | HENDRICKSON | AMANDA | | WILLISON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | UNKNOWN | EDWIN HENDRICKSON | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS — - - - -

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ADDRESS (Street, city, town, or county): RT. 9, CUMBERLAND, MARYLAND

22b. DATE SIGNED: Aug. 29, 1969

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 8/30/1969 | P.O.S. of A. CEMETERY | CENTREVILLE, BEDFORD, PA. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| BYRON KIGHT | CUMBERLAND, MD. | SEP 2 1969 | Nicholas Judge |

VR A15ME (5)
10M REV. 1/68

1

10732

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10729

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| CORA | M. | HITE | AUGUST | 29, | 1969 | 9:25 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 3-17-1875 | 94 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNA. | U.S.A. | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| PENNA. | BEDFORD | HYNDMAN | YES / NO | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| CHARLES | | DORN | AMANDA | | PISEL |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 207-42-2681 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Hypostatic Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: about 3 days

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arteriosclerotic Cardio-vascular disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| None | | YES / NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING [X] OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. / P.M. Month Day Year | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | July 27 1969 | Accidently fell at Home |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | Home | | HYNDMAN | Bedford | Penna |

22a. **I certify** that (I) (this hospital) attended the deceased from 8-27, 19 69, to 8-29, 19 69, that (I) (~~we~~) last saw the deceased alive on 8-29 19 69, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. / MED. DIRECTOR / STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|
| William R. Wolverton MD | | [X] | 9-2-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. WILLIAM R. WOLVERTON | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 31, 1969 | Hyndman Cemetery | Hyndman, Bedford, Pa. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Harvey H | Zeigler, Hyndman, Pa. | SEP 8 1969 | Florence Judge |

VR A15 (4)
45M - 1/69

1

10733

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10730

# CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health priar to burial, cremotion, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: MABEL | Middle: KATHERINE | Last: HOOVER | 2a. DATE OF DEATH: 08 Month, 13 Day, 69 Year | 2b. HOUR: 8:40A M |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 06 28 30 | 6. AGE (In years last birthday): 39 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH: ALLEGANY CO., Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Spotter | 12b. KIND OF BUSINESS OR INDUSTRY: Dry Cleaning Est. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: FROSTBURG | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 49 E. MAIN ST. | |
| 14. FATHER'S NAME: First SILAS | Middle | Last: WILT | 15. MOTHER'S MAIDEN NAME: First (FAZENBAKER) MARY | Middle | Last: (WILT) HUNTER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 218 48 9875 | 17. INFORMANT: PATIENT'S CHART | Address: 900 SETON DRIVE CUMBERLAND, MD. | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Irreversible uremia & hypocalcemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic nephritis — 7 days

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote | |

22a. **I certify** that (I) (this haspital) attended the deceased from Aug.6, 1969, to Aug.13, 1969, that (I) (we) last saw the deceased alive an Aug.12 1969, and that in (my) (aur) opinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: G. Paige Strong, Jr. M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: Aug.13,1969

22d. PHYSICIAN'S NAME (Type): A.Paige Strong — 22e. ADDRESS: 167 E.Main St.-Frostburg,Md.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE: 8/15/69 | 23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: GEORGE FUNERAL HOME, CUMBERLAND, MD. 21502 | ADDRESS: H. Wayne George | 25a. REC'D BY REGISTRAR DATE: AUG 18 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

VR A15 (2)
45M - 1/69

10734

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10731

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: JESSE | Middle: E | Last: HOPCRAFT | 2a. DATE OF DEATH: Month 8 Day 13 Year 69 | 2b. HOUR: 10:45 A M | |
| 3. SEX: MELE | 4. RACE: WHITE | 5. DATE OF BIRTH: 10-12-93 | 6. AGE (In years last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 219 MARYLAND AVE. | | |
| 14. FATHER'S NAME First: JOHN | Middle | Last: HOPCRAFT | 15. MOTHER'S MAIDEN NAME First: MOLLIE | Middle | Last: RHODES | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): Yes (If yes give war or dates of service): WW I | 16b. SOCIAL SECURITY NO.: 214-05-8634 | 17. INFORMANT: MEMORIAL HOSPITAL | Address: CUMBERLAND, MD. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO, OR AS A CONSEQUENCE OF

(b): Arteriosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 8-4-, 1969, to 8-13-, 1969, that (I) ~~(we)~~ last saw the deceased alive on 8-12- 1969 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: W. F. Williams DEGREE | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 8-14-69 | |
| 22d. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS | 22e. ADDRESS: CUMBERLAND, MD. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 8/16/69 | 23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. | 23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md | |
| 24. FUNERAL DIRECTOR: Lewis Stein Inc. | ADDRESS: Cumb. Md. | 25a. REC'D BY REGISTRAR DATE: AUG 18 1969 | 25b. REGISTRAR'S SIGNATURE: Charles E. Lodge | |

VR A15 (4)
45M - 1/68

FOR STATE HEALTH DEPT.

10735

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10732

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Albion | Middle: Mowbray | Last: Hyde | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] | Month: AUGUST | Day: 31 Year: 1969 | 2b. HOUR: 4:05 P.M. |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Feb. 18, 1901 | 6. AGE (In years last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | 2c. DATE PRONOUNCED DEAD: Month AUGUST Day 31, Year 1969 | 2d. HOUR: 4:04 P.M. |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired | 12b. KIND OF BUSINESS OR INDUSTRY: R.R. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Barton | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: Rt. #1 | | | |
| 14. FATHER'S NAME First: Alfred Hyde | Middle | Last | 15. MOTHER'S MAIDEN NAME First: Katherine Mowbray | Middle | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-05-8025 | 17. INFORMANT: Rose Hyde | ADDRESS: Moscow Mills, Md. | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS — ----

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 409

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: August 31, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/3/69 | 23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill | 23d. LOCATION (City or Town) (County) (State): Moscow Mills, Alle. Md. | |
| 24. FUNERAL DIRECTOR: E. L. Boal | ADDRESS: Westernport, Md. 21562 | 25a. REC'D BY REGISTRAR DATE: SEP 3 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

VR A15ME (5) 10M REV. 1/68

Items 7,8,&10 Film Ch 15
8/11/69 kk

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10736

10733

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Bertha | Middle: A. | Last: Innes | 2a. DATE OF DEATH Month: Aug | Day: 22 | Year: 1969 | 2b. HOUR: 2:00 A.M. |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: 3/4/92 | 6. AGE (In years last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Cash Valley / Cumberland Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 511 Richl Ave | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 511 Richl Ave | | | |
| 14. FATHER'S NAME First: George | Middle | Last: Helmstetter | 15. MOTHER'S MAIDEN NAME First: Sabina | Middle | Last: Rarick | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 213-24-7474 | 17. INFORMANT: Mr. Louis Helmstetter | Address: Cumb. Md | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
DIABETES MELLITUS

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from _____, 19 61, to 8-2, 19 69, that (I) (~~we~~) last saw the deceased alive on 7-15-1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|
| L. Michael Golick | | 8-2-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L. MICHAEL GOLICK | 912 SETON DR CUMBERLAND |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/6/69 | St. Peter + Paul Cem. | Cumberland Allegany Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Louis Stein Inc. | Cumb Md | AUG 6 1969 | |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10737 — 10734

1. DECEASED-NAME (Type or print): First William; Middle H.; Last Inskeep
2a. DATE OF DEATH: Aug. Month 3 Day 69 Year
2b. HOUR: 2 P.M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: April 27, 1889
6. AGE (In years last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sylvan Retreat
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: McCoole
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER:
14. FATHER'S NAME: First William; Middle; Last Inskeep
15. MOTHER'S MAIDEN NAME: First Goldie; Middle; Last Miller
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.:
17. INFORMANT: Evers Smith * Piedmont, W.Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilat. Bronchopneumonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: approx. 2 days.
DUE TO, OR AS A CONSEQUENCE OF (b): Senile C.V.D. — 9 days.
DUE TO, OR AS A CONSEQUENCE OF (c): Arteria-Sclerosis — many years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Prostat Hypertrophy. Chr.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from April 15 19 67, to Aug. 3, 1969, that (I) (we) last saw the deceased alive on Aug. 3 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John A. Tapper MD — DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. DATE SIGNED: 8-4-69
22d. PHYSICIAN'S NAME (Type): John A Tapper MD
22e. ADDRESS: Memorial Hospital Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 8/5/69
23c. NAME OF CEMETERY OR CREMATORY: Philos
23d. LOCATION (City or Town) (County) (State): Westernport, Md.
24. FUNERAL DIRECTOR: E. L. Boul — ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE: AUG 7 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

10738

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 10735

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| KILGORE | NMI | IZZETT | 08 04 69 | 8:25A |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 5-15-01 | 68 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | NONE | NONE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | MT SAVAGE | | NONE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| ROBERT | | IZZETT | JANET | | WYPER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 705-05-4670 | HOSPITAL REC., 900 SETON DR., CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia - left lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 486X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Advanced Pulmonary Emphysema -

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| ✓ | ✓ | | ✓ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | ✓ | ✓ |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | ✓ | ✓ | | ✓ | |

22a. **I certify** that (I) (this hospital) attended the deceased from 8-1, 1969, to 8-4, 1969, that (I) (we) last saw the deceased alive on 8-4 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| M.M. Rothstein | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 8-4-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| M.M. ROTHSTEIN MD | 48 BROADWAY, FROSTBURG, MD. 21532 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | AUGUST 6, 1969 | METHODIST CEMETERY | MT. SAVAGE ALLEGANY MD |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| DURST FUNERAL HOME | FROSTBURG MD | AUG 11 1969 | Charles Judge |

VR A (5) 4) 45M 69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10739

# CERTIFICATE OF DEATH

10736

| 1. DECEASED-NAME (Type or print) | First | Middle | Last | 2a. DATE OF DEATH | 2b. HOUR |
|---|---|---|---|---|---|
| | NORA | C. | KELLY | Month 8 Day 18 Year 69 | 7:25 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| FEMALE | WHITE | 9-25-94 | 74 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| WEST VIRGINIA | UNITED STATES | NEVER MARRIED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | NONE RETIRED CELANESE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | WESTERNPORT | YES [X] NO [ ] | 300 MARYLAND AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | J | KELLY | CATHERINE | | GARRITY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 232-01-1285 | HOSPITAL RECORD | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MULTIPLE MYELOMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 MOS

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

203X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

ACVD

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 2-13, 1969, to 8-18, 1969, that (I) (we) last saw the deceased alive on 8-18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| R.W. Ballin M.D | M.D | [X] | [ ] | [ ] | 8-18-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| R.W. BALLIN, M.D. | 62 GREENE ST CUMBERLAND, MD 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 8-21-69 | St. Peter's Cemetery | Westernport Alle. Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| FREDLOCK FUNERAL HOME, PIEDMONT, W. VA. | AUG 25 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

10289

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10740

# CERTIFICATE OF DEATH

10737

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| BARTHOLOMEW | J. | KILROY | 08 22 69 | 1:12P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 07-03-93 | 76 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VA. | UNITED STATES | | ALLEGANY CO. Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | MEMORIAL HOSPITAL | RETIRED | GROCERER |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY CO. | CUMBERLAND | | 616½ FREDERICK ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | W. | KILROY | DEHLIA | | BEANNEAR |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| YES | WW 1 | 214 05 8118 | MEMORIAL HOSPITAL | CUMB. MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute Myocardial Failure | Immediate |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Myocardial Infarction | 12 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriosclerotic HD | 12 days |

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Pesseno Confection of the hip

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 8/10, 1969, to 8/22, 1969, that (I) (we) last saw the deceased alive on 8/22 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | | [X] | [ ] | [ ] | 8/24/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. WEISMAN | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | AUG. 25, 1969 | HILL CREST BURIAL PARK | CUMBERLAND MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| BYRON KIGHT | CUMBERLAND, MD. | AUG 26 1969 | [signature] |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (6)
45M - 1X69

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10741

# CERTIFICATE OF DEATH

10738

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: ZELLIE Middle: STELLA Last: LEASE | | 2a. DATE OF DEATH Month 8 Day 19 Year 69 | 2b. HOUR 8:15 P.M. |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: ********* 8/23/01 | 6. AGE (In years last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (State or foreign country): PENNA. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HWF | 12b. KIND OF BUSINESS OR INDUSTRY: HOME |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: LA VALE | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 18 ASBURY AVE |
| 14. FATHER'S NAME First: NERIY Middle: Last: DICKEN | | 15. MOTHER'S MAIDEN NAME First: ALICE Middle: Last: BRANT | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: SACRED HEART HOSPITAL PTS. CHART 900 SETON DRIVE CUMB., MD. 21502 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): acute myocardial infarct
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 410.9
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hr / year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Carcinoma of cervix

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: V. E. Mazzocco DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | | | 22c. DATE SIGNED: 8-22-69 |
| 22d. PHYSICIAN'S NAME (Type): V. EUGENE MAZZOCCO, M.D. | | 22e. ADDRESS: 912 SETON DRIVE CUMB., MD. 21502 | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 8/22/69 | 23c. NAME OF CEMETERY OR CREMATORY: Lease Cemetery | 23d. LOCATION (City or Town): Nr. Cresaptown | (County): Allegany (State): Md. |
| 24. FUNERAL DIRECTOR: H. Wayne George ADDRESS: GEORGE FUNERAL HOME-202 GREENE ST., CUMB., MD. 21502 | | 25a. REC'D BY REGISTRAR DATE: AUG 25 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

VR A15 (M)
45M - 1/69

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10742

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10739

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Jesse | Middle: Clarence | Last: Lepley | 2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ | Month: 8 | Day: 24 | Year: 1969 | 2b. HOUR: 1:45 A M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: July 7, 1886 | 6. AGE (In years last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month 8 | Day 24 | Year 1969 | 2d. HOUR: 1:45 A M |

| | | | | |
|---|---|---|---|---|
| 7a. BIRTHPLACE (State or foreign country): Penna | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital-DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Carpenter - | 12b. KIND OF BUSINESS OR INDUSTRY: Self Employed | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: LaVale | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: 7 Woodlawn Avenue |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME: First Simon / Middle / Last Lepley | 15. MOTHER'S MAIDEN NAME: First Mary / Middle / Last Shoemaker | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 194-01-2813 | 17. INFORMANT: Mrs. Edith Lepley | ADDRESS: 7 Woodlawn Ave LaVale, Maryland |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

(b): CORONARY SCLEROSIS — ----

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS(Street, city, town, or county): CUMBERLAND, MD

22b. DATE SIGNED: August 24, 1969

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 8/27/69 | 23c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Memorial Gardens | 23d. LOCATION (City or Town) (County) (State): LaVale Allegany Maryland | |
| 24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service. | ADDRESS: 21502 Cumberland, Md | 25a. REC'D BY REGISTRAR DATE: AUG 28 1969 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | |

VR A15ME (5) 10M REV. 1/68

10743

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10740

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Leon | Claire | Liller | August 18, 1969 | 11:22 a m |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | White | Feb. 6, 1927 | 42 YRS. | | | August 18, 1969 | 11:22 a M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| Ellamore W. Va. | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | MEMORIAL HOSPITAL | Brakeman | B.O. RR |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. Va. | Mineral | Keyser | | 612 W. Piedmont Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Leslie | Carlton | Liller | Goldie | Blanche | Lanham |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW II | 235-36-4840 | Mrs. Margaret Liller, 612 W. Piedmont | St. Keyser, W.Va |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

819.9

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | LOBAR PNEUMONIA, BILATERAL | 3-4 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | (EXTENSIVE TRAUMA WITH TRAUMATIC AMPUTATION OF LEFT LEG) | 8 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) | AUTOMOBILE ACCIDENT | 8 days |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 12:15xxx August 10, 1969 | Automobile accident |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | INDUSTRIAL BLVD. | CUMBERLAND, ALLEGANY, MARYLAND |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [XX] Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Benedict Skitarelic M.D. BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]
22b. DATE SIGNED AUGUST 18, 1969
ADDRESS(Street, city, town, county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/21/69 | Potomac Valley Memorial Park | Keyser, Mineral W. Va |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Harold W. McKenzie Markwood Funeral Home Keyser, W. Va. | AUG 22 1969 | Charles Judge |

VR A15ME (5)
10M REV. 1/68

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FN3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10744

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10741

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First | Middle | Last | | | | | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] | Month | Day | Year |
| | WILLIAM | JOSEPH | LINDNER | | | | | | August | 25, | 1969 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. | 2b. HOUR | | | |
| Male | White | July 27, 1918 | 51 YRS. | | | | | 11:45 a.m. | | | |
| 2c. DATE PRONOUNCED DEAD | Month | Day | Year 19 | 2d. HOUR | | | | | | | |
| | August | 25, | 1969 | 11:45a.m. | | | | | | | |

| | | | | |
|---|---|---|---|---|
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH | |
| Maryland | U.S.A. | | Allegany | Md. |

| | | | |
|---|---|---|---|
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cumberland | DOA--Sacred Heart Hospital | Electric Truck Driver | Celanese, Inc |

| | | | | |
|---|---|---|---|---|
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
| Maryland | Allegany | Cumberland | YES [X] NO [ ] | 511 Princeton Street |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | |
| Joseph M. Lindner | | Elizabeth Knoche | |

| | | | |
|---|---|---|---|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
| Yes | WW II | 217-10-7026 | Mrs. Mary Lindner, 511 Princeton St., Cumb., Md |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Coronary thrombosis, left | Sudden |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary sclerosis | -- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [XX] NO [ ] |

| | | | |
|---|---|---|---|
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. **I certify** that I took charge of the remains described above, held on Autopsy [X], Inspection [XX], Inquiry [XX] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: August 25, 1969

ADDRESS (Street, city, town, or county): Cumberland, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | 8-28-69 | Hillcrest Burial Park | Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR | ADDRESS | | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
| John J. Hafer, JR. | 230 Balto. Ave., Cumberland, Md. | | AUG 28 1969 | Charles Judge |

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10745 10742

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: WILLIAM | Middle: JESS | Last: LLOYD | 2a. DATE OF DEATH Month: AUGUST Day: 5 Year: 1969 | 2b. HOUR: 7:55 PM |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 3-17-06 | 6. AGE (In years last birthday): 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): CUMB. MD. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED XX / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, MD. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Boilermaker | 12b. KIND OF BUSINESS OR INDUSTRY: Helper-RR | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. VA. | 13b. COUNTY: MINERAL | 13c. CITY OR TOWN: RIDGELEY | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ X | 13e. STREET AND NUMBER: ROUTE #1 | |
| 14. FATHER'S NAME First: WILLIAM | Middle: M | Last: LLOYD | 15. MOTHER'S MAIDEN NAME First: ALICE | Middle: ? | Last: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Chronic Thrombosis of the Inferior Vena — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF: Cava

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 189.0

(b) Hypernephroma of the right kidney — 6 mos. years

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Hypertensive Cardiovascular Disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. I **certify** that (I) (this haspital) attended the deceased from 1956, 19__, to Aug., 1969, that (I) (We) last saw the deceased alive an Aug. 5, 1969, and that in (my) (our) apinian death accurred an the date and haur and fram the causes stated above, (I) ~~have~~ (did) (did nat) view the bady after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 8-7-69

22d. PHYSICIAN'S NAME (Type): DR. G. OVERTON HIMMELWRIGHT — 22e. ADDRESS: 133 VIRGINIA AVE., CUMBERLAND, MD

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Aug.8,1969 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park | 23d. LOCATION (City or Town): Cumberland, | (County): Allegany, | (State): Md. |
| 24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. | ADDRESS | 25a. REC'D BY REGISTRAR DATE: AUG 11 1969 | 25b. REGISTRAR'S SIGNATURE: [signature] | | |

VR A15 (4) 45M - 1-69

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10746

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10743

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: EVA | Middle: IRENE | Last: LOAR | 2a. DATE OF DEATH Month: 8 | Day: 27 | Year: 69 | 2b. HOUR: 11:50 AM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 01-26-93 | 6. AGE (In years last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL-DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HWF | 12b. KIND OF BUSINESS OR INDUSTRY: HOME | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: LA VALE | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 1067 NATL HWY | | | |
| 14. FATHER'S NAME First: MORRIS | Middle | Last: PORTER | 15. MOTHER'S MAIDEN NAME First: ANN | Middle | Last: REPHANN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO | (If yes give war or dates of service) XXXXXXXXXX | 16b. SOCIAL SECURITY NO.: 214-05-4394 | 17. INFORMANT: HOSPITAL CHART | Address: SACRED HEART HOSPITAL 900 SETON DRIVE CUMBERLAND, MD. 21502 | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | MYOCARDIAL INFARCTION | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | ARTERIOSCLEROSIS GENERALIZED | 10 YRS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
DIABETES MELLITUS

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from _____, 19 62, to 8-27, 19 69, that (I) (~~we~~) last saw the deceased alive on 8-14 19 69, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: L M Glick | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 8-29-69 | |
| 22d. PHYSICIAN'S NAME (Type): L. M. GLICK, M.D. | 22e. ADDRESS: 912 SETON DRIVE, CUMB., MD. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 8/30/69 | 23c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Gardens | 23d. LOCATION (City or Town) (County) (State): LaVale, Allegany, Maryland | |
| 24. FUNERAL DIRECTOR: HAFER FUNERAL HOME | ADDRESS: 230 BALTO AVE., CUMB., MD. 21502 | 25a. REC'D BY REGISTRAR DATE: SEP 2 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

VR A15 (4)
45M - 1-68

10746

EVA IDENE LOAN 27 69:11:50

FEMALE WHITE 01-26-93 75

MARYLAND U.S.A. ALLEGANY

CUMBERLAND SACRED HEART HOSPITAL-DOA HWF HOME

MARYLAND ALLEGANY LA VALE 1007 NATL HWY

NORRIS PORTER ANN REFERRED

NO [illegible] HOSPITAL CHART SACRED HEART HOSPITAL 900 SETON DRIVE CUMBERLAND, MD. 21502

L. M. GLICK, M.D. 912 SETON DRIVE, CUMB., MD. 21502

Burial 8/30/69 Rentlawn Memorial Gardens LaVale, Allegany, Maryland

HAFER FUNERAL HOME 230 BALTO AVE., CUMB., MD. 21502

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

10747 10744

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| FRANCIS | PATRICK | LOUGHNEY | 08 11 69 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 03-07-00 | 69 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | NEVER MARRIED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | RETIRED | HOTEL |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [X] NO [ ] | 55 BOWERY ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | | LOUGHNEY | CATHERINE | | KELLY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 018-10-1747 | HOSPITAL REC., 900 SETON DR., CUMBERLAND, MD. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Pneumonia | 3 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Post operative debility | 4 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Bronchiolar Carcinoma of lung | 6 mo |

1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Megacolon - Superior mesenteric artery Thrombosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 6 Aug 69 | Carcinoma of Lung | YES [X] NO [ ] | yes |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** thot (I) (this hospital) ottended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date ond hour and from the causes stoted obove, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| V. E. Mazzocco MD | | [X] | [ ] | [ ] | 8-11-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| V. E. MAZZOCCO MD | 912 SETON DR., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 8-13-1969 | St. Michaels Cemetery | Frostburg, Alleg. Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DURST FUNERAL HOME, 57 FROST AVE., FROSTBURG, MD. 21532 | AUG 14 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be detached for use as the burial-transit permit. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(1)
45M - 1-69

10757

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10748

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10745

# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: JAMES | Middle: L. | Last: MOROZEK | 2a. DATE OF DEATH Month: 08 Day: 06 Year: 69 |
| 2b. HOUR: 9:30 P.M. | | | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 01-23-34 | 6. AGE (In years last birthday): 35 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY COUNTY, Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): JANITOR-ORT'S BAKERY | 12b. KIND OF BUSINESS OR INDUSTRY: BAKERY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] |
| 13e. STREET AND NUMBER: 206 PEAR STREET | | | |
| 14. FATHER'S NAME First: STEVEN | Middle: L. | Last: MOROZEK | 15. MOTHER'S MAIDEN NAME First: (BUTLER) MAE |
| Middle: | Last: MOROZEK | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): YES (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 199-24-3504 | 17. INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB., Address MD. 21502 | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): UREMIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 MOS

582X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CHRONIC GLOMERULO-NEPHRITIS — 4 YEARS

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CONGESTIVE HEART FAILURE. SECONDARY ANEMIA

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 4 - 7, 1969, to 8 - 6, 1969, that (I) (we) last saw the deceased alive on 8 - 6 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: R.W. Ballin M.D. | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type): R.W. BALLIN, M.D. | 22e. ADDRESS: 62 GREENE ST., CUMBERLAND, MD. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): burial | 23b. DATE: 8/11/69 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: R.C. Newman | ADDRESS: NEWMAN FUNERAL HOME, GRANTSVILLE, MD. 21536 | 25a. REC'D BY REGISTRAR DATE: AUG 14 1969 | 25b. REGISTRAR'S SIGNATURE: R. Charles Judge | |

VR A15(4)
45M - 1-69

Item5 FilmG415
8/8/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10746

# 10749 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Mary | Middle: Genevieve | Last: Morris | 2a. DATE KNOWN OF DEATH X / ESTIMATED: Month August, Day 2, Year 1969 | 2b. HOUR 12:45 P M | | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: May 2, 1901 / Aug. 2, 1969 | 6. AGE (In years last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month August, Day 2, Year 1969 | 2d. HOUR 12:45 P M | |
| 7a. BIRTHPLACE (State or foreign country): W. Va. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 121 Pennsylvania Ave. | | | | |
| 14. FATHER'S NAME First: William | Middle: A. | Last: Davis | 15. MOTHER'S MAIDEN NAME First: Eliza | Middle: | Last: Fineran | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. James G. Honeycutt | ADDRESS: Daughter, Wheaton, Md. | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 — DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | ---- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)
22b. DATE SIGNED: August 2, 1969
ALLEGANY

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Aug. 5, 1969 | 23c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: James F. Scarpelli | ADDRESS: Cumberland, Md. | 25a. RECD BY REGISTRAR DATE: AUG 6 1969 | 25b. REGISTRAR'S SIGNATURE: Edwards Judge | |

VR A15ME (5)
10M REV. 1/68

10749

Mary Genevieve Morris August 2, 1969

Female White Aug. 2, 1969 60 August 2, 1969 12:45p

W. Va. USA Allegany

Cumberland Memorial Hospital Roundsville Own Home

Md. Allegany Cumberland X 121 Pennsylvania Ave.

William A. Davis Eliza Finerman

Daughter

no Mrs. James G. Honeycutt, Wheaton, Md.

CORONARY CONCLUSION SUDDEN

CORONARY SCIENTIFIC ----

XX

X

August 2, 1969

BENEDICT SHIRAZELIC, M.D. ALLEGANY

Burial Aug. 5, 1969 St. Patrick's Cemetery Cumberland, Allegany, Md.

James F. Scarpelli, Cumberland, Md.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10750

# CERTIFICATE OF DEATH

10747

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ANN | | O'BRIEN | 8 10 69 | 12:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 4-29-16 | 53 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED X NEVER MARRIED WIDOWED DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES X NO | 203 FIFTH ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | | LIPOLD | THERESA | | MALETICH |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | UNKNOWN | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | (1) Anoxia (2) Bronchial plugging from Hemoptysis | 2 |
| DUE TO, OR AS A CONSEQUENCE OF (b) | (3) Bilateral apical pulmonary TBC, active, advanced | ? |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

011.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Active duodenal ulcer 2 year

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES X NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | Yes |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 8/5, 1969, to 8/10, 1969, that (I) (we) last saw the deceased alive on 8/10 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| S. G. Weisman | | | | X | 8/11/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. S. G. WEISMAN | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | AUG. 13, 1969 | ST. MARYS CEMETERY | CUMBERLAND, MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| BYRON KIGHT | CUMBERLAND, MD. | AUG 15 1969 | Clinton Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

10751

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10748

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: OSCAR | Middle: NMI | Last: PETERSON | 2a. DATE OF DEATH Month: 8 Day: 17 Year: 69 | 2b. HOUR: 11:10 AM |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 6-1-05 | 6. AGE (In years last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): NEW HAMPSHIRE | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED-U.S. GOVERNMENT CIA | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: 109 WESTWOOD ROAD -BEL AIR | |
| 14. FATHER'S NAME First: NILS ***** | Middle | Last: PETERSON | 15. MOTHER'S MAIDEN NAME First: MATILDA | Middle | Last: GUSTAFSON |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: YES (If yes give war or dates of service): WW II | 16b. SOCIAL SECURITY NO.: 217-44-9665 | 17. INFORMANT: HOSPITAL RECORD | Address | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: one week

492X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary Emphysema — ten years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. I **certify** that (I) (this hospital) attended the deceased from Jan, 19 67, to 8-17, 19 69, that (I) (we) last saw the deceased alive on 8-17 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: Wayne C Spiggle | MD DEGREE | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] | 22c. DATE SIGNED: 8-18-69 |
| 22d. PHYSICIAN'S NAME (Type): WAYNE C. SPIGGLE, M.D. | 22e. ADDRESS: 912 SETON DRIVE, CUMB., MD. 21502 | | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 8/20/69 | 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | 23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland | |
| 24. FUNERAL DIRECTOR: SILCOX FUNERAL HOME MERRITT* | ADDRESS: Cumberland, Md | 25a. REC'D BY REGISTRAR DATE: AUG 20 1969 | 25b. REGISTRAR'S SIGNATURE: [signature] | |

VR A15 (3) 45M - 1/69

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10752 — 10749

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month, Day, Year | 2b. HOUR |
|---|---|---|---|---|---|
| George | Allen | Phillips | X | AUGUST 5, 1969 | 8:40 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | White | 8/29/1915 | 53 YRS. | | | AUGUST 5, 1969 | 9:20 M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. Va | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | MEMORIAL HOSPITAL--DOA | Employee- Kelly Springfield Tire Co | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W.Va | Mineral | Ridgeley | YES / NO X | Carpenters Addition |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Columbus | | Phillips | Florence | | Johnson |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW II | 217-10-4344 | Mrs. Wreatha L. Phillips | Carpenters Additio Ridgeley, W. Va |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY THROMBOSIS | -- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | CORONARY SCLEROSIS | -- |

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Rheumatic aortic valvulitis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21a. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described obave, held an Autopsy X, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined monner

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED AUGUST 5, 1969

ADDRESS(Street, city, town, or county) ALLEGANY

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/8/69 | Sunset Memorial Park | Cumberland Allegany Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Silcox-Merritt Funeral Service. Cumberland, Md | 21502 | AUG 8 1969 | Wilmer Judge |

VR A15ME (5)
10M REV. 1/68

10323

1

10753

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10750

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: INA | Middle: LEECTA | Last: ROBINSON | 2a. DATE OF DEATH Month: 08 Day: 19 Year: 69 | 2b. HOUR: 9:30A M |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 03-06-30 | 6. AGE (In years last birthday): 39 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP. | 12a. USUAL OCCUPATION (Kind of work done during most of working life. Retired.): HOME Co-Owner | 12b. KIND OF BUSINESS OR INDUSTRY: Restaurant | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD. | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 515 SHERIDAN PLACE | |
| 14. FATHER'S NAME First: WALTER | Middle: GEORGE | Last: BENDER | 15. MOTHER'S MAIDEN NAME First: AUDRA | Middle: HAZEL | Last: HENDERSON |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-26-7540 | 17. INFORMANT: HOSPITAL REC., CUMBERLAND, MD. | Address: 215 2 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia

DUE TO, OR AS A CONSEQUENCE OF (b): Bilateral Ureteral Obstruction

DUE TO, OR AS A CONSEQUENCE OF (c): Carcinoma of Cervix, Terminal

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

180X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: A. Valdes M.D. | DEGREE | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] | 22c. DATE SIGNED: 8-20-60 |
| 22d. PHYSICIAN'S NAME (Type): A. VALDES M.D. | | | | | 22e. ADDRESS: ALGONQUIN HOTEL, CUMBERLAND, MD. |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 8-22-69 | 23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cemetery | 23d. LOCATION (City or Town) (County) (State): Points, West Virginia | |
| 24. FUNERAL DIRECTOR: Charles E. Hafer, 230 Balto. Ave., Cumberland, Md. | ADDRESS | 25a. REC'D BY REGISTRAR DATE: AUG 25 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

VR A15 (4)
45M - 1/69

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10754

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10751

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Joseph | Owen | Shipley | Aug. 27, 1969 | 7:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | White | 12/19/1883 | 85 YRS. | | | August 27, 1969 | 7:30 PM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| Penna. | U S A | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | D.O.A. Memorial Hospital | Farmer (Retired) | Self |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Penna. | Bedford | Buffalo Millsxx | YES [ ] NO [ ] | ---- |

99
75
3

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Phillip | | Shipley | Catherine | | Martin |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 214-05-7656 | Freda Harvey | 503 Williams St. Cumberland Md |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 4123 | IMMEDIATE CAUSE (a) CORONARY OCCLUSION | SUDDEN |
| | DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS | -- |
| | DUE TO, OR AS A CONSEQUENCE OF (c) | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

2

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED August 27, 1969

ADDRESS(Street, city, town, and CUMBERLAND, MARYLAND

2

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/30/1969 | Hillcrest Burial Park | Near Cumberland Alleg Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| John J. Hafer, Jr., 230 Balto Ave. Cumberland Md | SEP 2 1969 | Clerk Judge |

VR A15ME (5) 10M REV. 1/68

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10755 — 10752

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| BEULAH | C. | SHUCK | 08 | 07 | 69 | 9:00 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN |
|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | OCTOBER 12, 1884 | 84 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | MINERS HOSPITAL | HOUSEWIFE | NONE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | ECKHART | | NONE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JAMES | | CECIL | ELIZABETH | | STARKEY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 214-07-0165 | MRS. GEORGE FIKE | 155 W MAIN FROSTBURG, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic CVD —
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
NONE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| ✓ | ✓ | | ✓ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| ✓ | ✓ | ✓ |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | ✓ | | ✓ | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 8-1, 1969, to 8-7, 1969, that (I) (we) last saw the deceased alive on 8-7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Marshall M Rothstein | | | | | 8-8-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| M.M. ROTHSTEIN MD | 48 BROADWAY, FROSTBURG, MD 21532 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | AUG 9, 1969 | ECKHART CEMETERY | ECKHART ALLEGANY MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R DURST SR. FROSTBURG, MD | AUG 11 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1-69

1

10756

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10753

# CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| GERTRUDE | E | SMELTZER | 8 8 69 | 6:35P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 12-19-00 | 68 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | HOUSEWIFE | OWN HOME |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 701 QUEBEC AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | J. | BARTIK | JOSEPHINE | SWACH | (SWAK) |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CEREBRAL INFARCTIONS, MULTIPLE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mos

4122

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL THROMBOSES — 3 mos

DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR RENAL DISEASE — 5 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

GOITRE Osteoarthritis Diverticulosis of Colon

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from ~~7-11~~, 19 64, to 8/8, 19 69, that (I) (we) last saw the deceased alive on 8/8 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE S. G. Weisman MD — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 8/9/69

22d. PHYSICIAN'S NAME (Type) Dr. S. G. Weisman, MD — 22e. ADDRESS 59 Greene St., Cumberland, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 11, 1969 | Rose Hill Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | AUG 13 1969 | J. Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (1) 45M 1/69

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SUE (5)
10M REV. 1/68

10757

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10754

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| WILLIAM | LESLIE | SNYDER |

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ Month Aug. Day 13 Year 1969 — 2b. HOUR 8 05 P M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | IF UNDER 1 YEAR: DAYS | IF UNDER 24 HRS.: HOURS | IF UNDER 24 HRS.: MIN. |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | JUNE 8, 1900 | 69 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month August Day 13 Year 1969 — 2d. HOUR 8 05 P M

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | MARRIED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | DOA - Memorial Hosp. | ELECTRICIAN - SELF EMPLOYED | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES X NO ☐ | 148 DEPOT STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| PETER | | SNYDER | ROSE | MAY | LANCASTER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| YES | WWI | 216-14-1003 | MRS. MARIE SNYDER, FROSTBURG, MD. 21532 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | *** |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO X** |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED August 13, 1969

ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | AUG. 16, 1969 | ECKHART CEMETERY | ECKHART, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | AUG 18 1969 | Charles Snyder |

1

10758

Items 14&15 Film G416 9/9/69 kk

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

10755

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2o. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| FRANK | H. | STUBY | AUGUST 27 1969 | AM 2:23 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 3-23-1900 | 69 YRS. | | |

| 7o. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNA. | UNITED STATES | MARRIED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | MEMORIAL HOSPITAL | Calender Room | Tire Manuf. |

| 13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES / NO | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES X NO | 618 ELWOOD ST. |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Henry | GEORGE/ | Stuby | Amanda | /ELIZABETH | Wolford STEINBAUGH |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 217-10-6602 | MEMORIAL HOSPITAL CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (o) | Cerebral hemorrhage with left hemiplegia | 25 aug. 69 |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Myocardial degeneration, arteriosclerosis | 23 aug. 69 |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Diabetes mellitus, severe | 23 aug 69 |

2509

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

Diabetes mellitus severe 19 yrs. H.B.P. Cardiovascular disease 19 yrs.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20o. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | NO X | |

| 21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot (I) (this hospital) attended the deceased from July, 1950, to 27 aug., 1969, that (I) ~~(we)~~ last saw the deceased alive an 26 aug 1969, and that in (my) ~~(our)~~ opinian death accurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did nat) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| W. Alfred Van Ormer, M.D. | | | X | | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W.A. VAN ORMER | 122 S. Center St., City |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | Aug. 29, 1969 | Hillcrest Burial Park | Cumberland Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25o. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli Cumberland, Md. | SEP 2 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10759

# CERTIFICATE OF DEATH

10756

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| MARGARET | E. | THOMAS | AUGUST 11 1969 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| FEMALE | WHITE | DEC. 14, 1913 | 55 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VA. | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | MINERS HOSPITAL | WEAVING SHED | CELANESE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [X] NO [ ] | 8 MILL STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| HENRY | M. | BROWN | JANE | R. | HOTCHKISS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | 214-07-2150 | HARRY E. THOMAS, SR., FROSTBURG, MD. 21532 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Massive Coronary Occlusion | 18 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Artery Disease | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Generalized Arteriosclerosis | years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Severe Diabetes Mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19 65 to Aug 11, 19 69, that (I) (we) last saw the deceased alive on Aug 10 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Leslie Miles MD | | [X] | [ ] | [ ] | 8.13.69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| LESLIE MILES, M. D. | STATE STREET, LONACONING, MD. 21539 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | AUG. 14, 1969 | FBG. MEMORIAL PARK | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| JOSEPH R. DURST, | FROSTBURG, MD. 21532 | AUG 18 1969 | Charles Yontz |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

4 1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10760 — Item 5 Film G416 9/5/69 kk — 10757

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: FRED, Middle: B. Last: VALENTINE | | 2a. DATE OF DEATH: AUGUST Month 17 Day 1969 Year | 2b. HOUR OF DEATH: 1:15 PM |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 7-9-1909 | 6. AGE (In years last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (State or foreign country): W.VA. | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, MD. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): STONE MASON | 12b. KIND OF BUSINESS OR INDUSTRY: BUILDING |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET AND NUMBER: 1137 FREDERICK ST. |
| 14. FATHER'S NAME First: FRANK Middle: Last: VALENTINE | | 15. MOTHER'S MAIDEN NAME First: ALICE Middle: Last: MARTIN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 236 12 1013 | 17. INFORMANT Address: MEMORIAL HOSPITAL CUMBERLAND, MD. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonitis + respiratory insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO, OR AS A CONSEQUENCE OF

(b): Pulmonary emphysema + fibrosis advanced — 15 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c): Colostomy for Carcinoma of Colon also ab. for recurrent carcinoma of colon — 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1538

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Heart Disease - Cor Pulmonale Bobek

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 8/13/69 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of Colon | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I **certify** that (I) (this hospital) attended the deceased from ____, 19 50, to 17 Aug, 19 69, that (I) (we) last saw the deceased alive on 17 Aug 1969, and that in (my) (our) opinion death occurred on the date and hour and from the couses stoted above, (I) (we) (did) (did nat) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Weisman M.D. DEGREE | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 8/22/69 | |
| 22d. PHYSICIAN'S NAME (Type): DR.S.G. WEISMAN | 22e. ADDRESS: 59 Greene St Cumberland, Md | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Aug. 20, 1969 | 23c. NAME OF CEMETERY OR CREMATORY: REST LAWN MEM. GARDENS | 23d. LOCATION (City or Town): CUMBERLAND, MD. | (County) (State) |
| 24. FUNERAL DIRECTOR: BYRON KIGHT | ADDRESS: CUMBERLAND, MD. | 25a. REC'D BY REGISTRAR: AUG 25 1969 | 25b. REGISTRAR'S SIGNATURE: Marian Cuse | |

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10761

# CERTIFICATE OF DEATH

10758

| 1. DECEASED-NAME (Type or print) | First | Middle | Last | 2a. DATE OF DEATH | 2b. HOUR |
|---|---|---|---|---|---|
| | NAN | RUTH | WIGFIELD | Month 8 Doy 2 Year 69 | 9:10AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
|---|---|---|---|---|---|---|---|
| | | | | MONTHS | DAYS | HOURS | MIN |
| FEMALE | WHITE | 6-12-91 | 78 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATE | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FLINTSTONE | YES [ ] NO [XX] | --- |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| FRANCIS | R. | WILSON | CORA | | DAVIS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | [redacted] 215-36-9596 | HOSPITAL RECORD | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 WKS

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4409

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS UNDERLYING | 21b. TIME OF INJURY | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer) | HOUR A.M. P.M. Month Doy Year 19 | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from 6/21/69, 19 69, to 8/2, 19 69, that (I) (we) last saw the deceased alive an 8/2 19 69 and that in (my) (aur) opinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | MD DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Wayne C Spiggle | | [X] | [ ] | [ ] | 8/3/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. SPIGGLE | 912 SETON DR., CUMB., MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/5/69 | Hillcrest Burial Park | Cumberland Allegany Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| SILCOX FUNERAL HOME | CUMBERLAND, MD. | DATE AUG 5 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4) 45M 11/69

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10762

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10759

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Josephine | Middle: | Last: Wilfong | 2a. DATE KNOWN OF DEATH ESTIMATED: Month Aug. Day 17 Year 1969 | | | 2b. HOUR 1:20 A M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: Aug. 1, 1920 | 6. AGE (Last birthday) 49 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month Aug. Day 17 Year 1969 | 2d. HOUR 1:20 A M |
| 7a. BIRTHPLACE (State or foreign country): W. Va. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 313 Springdale St. | | | |
| 14. FATHER'S NAME First: Edward | Middle: Shears | Last: | 15. MOTHER'S MAIDEN NAME First: Mattie E. | Middle: Smith | Last: | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Norma) ADDRESS: Mrs. Norma Nycum, Cumberland, Md. | Sister | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: DAYS
DUE TO, OR AS A CONSEQUENCE OF
(b): CORONARY SCLEROSIS — *------
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Naturol causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county)
22b. DATE SIGNED: August 17, 1969 Cumberland, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Aug. 20, 1969 | Sunset Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | AUG 19 1969 | |

VR A15ME (5)
10M REV. 1/68

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10763

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10760

# CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 52 85 3

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: LEORA | Middle: Dale | Last: WILT | 2a. DATE OF DEATH Month: 08 Day: 04 Year: 69 | 2b. HOUR: 7:10 A.M. |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 4-10-07 | 6. AGE (In years last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS 3 DAYS 24 | IF UNDER 24 HRS.: HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country): WEST VIRGINIA Moorefield | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE | 12b. KIND OF BUSINESS OR INDUSTRY: NONE | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: WEST VIRGINIA | 13b. COUNTY: MINERAL | 13c. CITY OR TOWN: KEYSER | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 580 W. PIEDMONT ST. | |
| 14. FATHER'S NAME First: BELL | Middle: B. | Last: BUCKLEY | 15. MOTHER'S MAIDEN NAME First: ANGIE | Middle: | Last: NEWHOUSE |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown: NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: None | 17. INFORMANT: HOSPITAL REC., | Address: 900 SETON DR., CUMBERLAND, MD. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary embolus - right — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: one week

DUE TO, OR AS A CONSEQUENCE OF (b): Thrombophlebitis left leg

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 451.0

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes mellitus, arteriosclerosis marked

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 7-21-69 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Gangrene big toe right | 20a. AUTOPSY? YES [X] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. I **certify** that (I) (this hospital) attended the deceased from 7-11-69, 19___, to 8-4, 1969, that (I) (we) last saw the deceased alive on 8-4, 1969, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Earl R. Paul | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 8-5-69 | |
| 22d. PHYSICIAN'S NAME (Type): EARL R. PAUL MD | 22e. ADDRESS: 414 N. MECHANIC ST., CUMBERLAND, MD. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 8-7-69 | 23c. NAME OF CEMETERY OR CREMATORY: Queens Point Cemetery | 23d. LOCATION (City or Town) (County) (State): Keyser, W.Va. (Mineral) | |
| 24. FUNERAL DIRECTOR: MARKWOOD FUNERAL HOME Harold W. McKenzie | ADDRESS: Keyser, W.Va. | 25a. REC'D BY REGISTRAR DATE: AUG 7 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Jenings | |

VR A15 (4)
45M - 1/69

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

10764

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10761

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| John | Fredrick | Zimmerman | 8 | 13 | 1969 | 8:45p |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD: Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | 9/5/1920 | 48 YRS. | | | | | 8 | 13 | 1969 | 8:45p |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | DOA-Sacred Heart Hospital | Lockologist | Self Employed |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES ☒ NO ☐ | 518 Holland Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| J | Fred | Zimmerman,Sr | Violet | | Welsh |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WWII | 219-14-6979 | Mrs. Violet I. Bender | 518 Holland Street Cumberland, Md |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Sclerosis — --
DUE TO, OR AS A CONSEQUENCE OF
(c)

4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, XXXXXXX, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED August 13, 1969

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

ADDRESS(Street, city, town, or CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 8/16/69 | Hillcrest Burial Park | Cumberland Allegany Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Silcox-Merritt Funeral Service. Cumberland, Md 21502 | AUG 18 1969 | Charles Judge |

VR A15ME (5)
10M REV. 1/68